MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09265

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, Institution, or street address where death occurred:
DOA Prince Georges General Hospital
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. of Col. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1144 44th Pl., S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: James Conroy Adams

3. (b) Social Security Number: 112 - 14 - 5068

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 18, 1895

8. AGE:

Years	Months	Days	If less than one day
52	8	23	hrs. min.

9. Birthplace: Ogdensburg, New York
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Building business

FATHER
12. Name: Matthew Adams
13. Birthplace: New York

MOTHER
14. Maiden name: Mary Burns
15. Birthplace: New York

16. Informant: William A. Skeen
Address: 1144 44th Pl., S.E., Wash., D.C.

17. (Burial, cremation, or removal. Which?) Transportation Date thereof: Oct 14, 1947 (month) (day) (year)

Cemetery or crematory: St Mary's
Location: Ogdensburg, New York.

18. Funeral director: P. J. Gasch's Sons
Address: Ft Meade, Md.

19. (Date rec'd by registrar) 10/13 1947 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12 1947, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage and Shock	
Due to: Fracture of skull	
Due to: Crushed chest	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of injury: 9-11-47
Where did injury occur? Seat Pleasant P.G. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Central Ave
Means of injury: Pedestrian struck by car
Manner of injury: Deputy medical Examiner

23. SIGNATURE: [illegible] M. D. or other
Address: Forestville Md. Date signed: 10-12-47

VS A15 9-45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13a

B 09265

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Prince George's

City or town: Forestville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred: 8343 Leona Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Norht Carolina County: Wilson

City or town: Kenly

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route # 1

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Cuzzie Faucette Barnes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Richard Barnes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25, 1889

8. AGE: Years: 58 Months: 5 Days: 4 If less than one day: hrs. min.

9. Birthplace: Norhh Carolina (Town, county, and state)

10. Usual occupation: Hoose wife

11. Industry or business: Own home

FATHER 12. Name: Stephen Davis

13. Birthplace: North Carolina

MOTHER 14. Maiden name: Fannie Johnson

15. Birthplace: North Ca rolina

16. Informant: Fannie Anderson

Address: 8343 Leona St., Forestville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-30-47 (month) (day) (year)

Cemetery or crematory:

Location: Kenly, N. C.

18. Funeral director: W. M. Chambers Co.

Address: 517 11th St. N. E.

19. Oct. 30 19 47 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29 19 47, at 10:35

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

Deputy Medical Examiner

23. SIGNATURE: James L. Boyd M. D. or other

Address: Forestville, Md. Date signed: 10/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1952 NT SB 09267

Reg. Diat. No. 239

1. PLACE OF DEATH:
County: Pr Geo
City or town: Laurel Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: Davis Home
How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Wash DC. County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6106 - 9th N.W. DC.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HARRY BATTISTA

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 24 - 1942

8. AGE: Years: 5 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Washington DC.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: John Battista
13. Birthplace: Washington DC.

MOTHER
14. Maiden name: Ethel Jenkins
15. Birthplace: Washington DC.

16. Informant: John Battista
Address: 6106 - 9th N.W. DC.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 9-1947 (month) (day) (year)
Cemetery or crematory: Ft Lincoln
Location: Wash. Blvd DC.

18. Funeral director: T. F. Costello
Address: 1722 - North Capitol St.

19. Oct 7 1947 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1947 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 30 1947 to October 5 1947 and that I last saw him alive on October 5 1947

Immediate cause of death	DURATION
Fever Undetermined Origin	1 week
Epistaxis	1 week
Due to:	
Due to:	
Other conditions: Cerebral Birth Injury Congenital Physical Retardation (Include pregnancy within 3 months of death)	5 years

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John Stephens, M.D.
M. D. or other
Address: Laurel Maryland Date signed: 10/7/47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09268

Reg. Diat. No. 239

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Days
Hospital, institution, or street address where death occurred: Warrens Hospital
How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Beltsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SAMUEL RODGERS BEALL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	SINGLE

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): OCT 14, 1880

8. AGE:

Years	Months	Days	If less than one day
67	—	10	..... hrs. ..... min.

9. Birthplace: BELTSVILLE, Md. (Town, county, and state)

10. Usual occupation: HIGHWAY DEPARTMENT

11. Industry or business: DIST. OF COL. GOV'T.

FATHER
12. Name: GEORGE WASH'N. BEALL
13. Birthplace: BRANCHVILLE, Md.

MOTHER
14. Maiden name: REBECCA FRANCES HALL
15. Birthplace: PRINCE GEO. CO., Md.

16. Informant: SUSIE C. BEALL
Address: BELTSVILLE, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: OCT 27 1947 (month) (day) (year)
Cemetery or crematory: ST JOHNS EPISCOPAL CHURCH CEM.
Location: BELTSVILLE, Md.

18. Funeral director: Gibson & Talley
Address: 505 WASH'N. BLVD., LAUREL, Md.

19. OCT 25 1947 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT. 24, 1947 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT 18 1947 to OCT 24 1947 and that I last saw him alive on OCT 24 1947

Immediate cause of death	DURATION
Uremia	
Due to: Arteriosclerotic Cardiovascular Renal Disease	
Other conditions: Primary Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. N. Warren M.D.
M. D. or other
Address: Laurel Date signed: 10/24/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9269

13 1a

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: 5015 - 54th Place
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Roger Heights Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Nellie Bates Bisel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Leo Bisel
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): oct 3. 1885

8. AGE: Years	Months	Days	If less than one day
62	0	28	....hrs. ....min.

9. Birthplace: Wheeling - west va
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: John Downs
13. Birthplace: West Va
MOTHER 14. Maiden name: Jennie McKay
15. Birthplace: Ohio.
16. Informant: Leo Bisel
Address: Hyattsville Md.
17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Nov 2, 1947 (month) (day) (year)
Cemetery or crematory: Pittsburg Pa.
Location:
18. Funeral director: E Bosch & Son
Address: Hyattsville Md.
19. Nov 4 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31. 1947 at 6.55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-9 1947 to 10-31 1947 and that I last saw h--- alive on 10-14 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	10 min
Due to: Hypertensive Cardio-Vascular-Renal Disease	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H R Breeyer M.D. M. D. or other
Address: Mt. Rainier Md. Date signed: 10-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2231

1. PLACE OF DEATH:

County: Prince George's

City or town: Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Inmate

Hospital, institution, or street address where death occurred:

Marlboro Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Hedgewood Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1107 - 53rd Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Booth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Maggie Booth

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 2, 1864

8. AGE: Years 83 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Skilled laborer

11. Industry or business: Retired

FATHER — 12. Name: James S. Booth

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elmira Jones

MOTHER — 15. Birthplace: Maryland

16. Informant: Elmira Foster

Address: 517 T Street NW. Washington DC

17. removal (Burial, cremation, or removal. Which?) Date thereof 10/21/47 (month) (day) (year)

Cemetery or crematory: Henry Wash. Funeral Home, Wash. DC.

Location:

18. Funeral director: F. Gosh's Sons

Address: Hyattsville Md

19. Oct 21 1947 (Date rec'd by registrar) Amanda H. Mooney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20, 1947, at 7 05 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Crushed chest, abdomen and pelvis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of injury 10-20-47

Where did injury occur: Upper Marlboro P.G. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Marlboro Pike

Means of injury: Pedestrian struck by car Injured by

Deputy Medical Examiner

23. SIGNATURE: James S. Boyd M. D. or Coroner

Address: Hyattsville Md Date signed: 10-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

COPY SENT TO ~~LOCAL~~ CHO. REGISTRAR No. _____ DATE 10/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

55 e

B 245

69271

Reg. Diat. No.

1. PLACE OF DEATH:

County Prince George's

City or town Riverdale Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Eugene Leland Memorial Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4021 Chesapeake St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Brooke, Mr. Phillip A.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1879

8. AGE: Years 68 | Months 7 | Days 11 | If less than one day ... hrs. ... min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Night Watchman

11. Industry or business

FATHER 12. Name Clement Hill Brooke

13. Birthplace Washington, D.C.

MOTHER 14. Maiden name Margaret Gustan

15. Birthplace Maryland.

16. Informant Head of Records

Address

17. Oct 14 - 47 (Burial, cremation, or removal. Which?) Date thereof Buried (month) (day) (year)

Cemetery or crematory Mt. Hope D.C.

Location Wash. D.C.

18. Funeral director H.W. Chambers

Address Riverdale Md.

19. Oct 14 1947 (Date rec'd by registrar) James Seve Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1947 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 1947 to Oct. 14 1947 and that I last saw h... alive on October 14, 1947

Immediate cause of death	DURATION
congestive heart failure	1 day
Due to lymphosarcomatosis	6 months +
Due to	
Other conditions left by Dr Thomas	2 days

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op.

Autopsy results lymphosarcomatosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. A. Scherpenberg Jr. M.D. M. D. or other

Address 4404 Queensberry Rd, Riverdale, Md. Date signed 10/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09272

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince Georges Co.
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George's
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Raymond Floyd Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Separated

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11- 4- 91

8. AGE: Years	Months	Days	If less than one day
55 ~~56~~	11	26	hrs. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Plumber
11. Industry or business

FATHER
12. Name James Brown
13. Birthplace Virginia

MOTHER
14. Maiden name Rosa Berkley
15. Birthplace Virginia

16. Informant Catherine Parker
Address 6701 Poplar St.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10- 30- 47 (month) (day) (year)
Cemetery or crematory Harmony Cemetery 11-1-47
Location Washington, D. C.
18. Funeral director Robinson & Hunt
Address 1820 - 9 St. NW Wash DC

19. Oct 31 (Date rec'd by registrar) 1947 James Levy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10. 30 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7. 18 1947, to 10. 30 1947
and that I last saw h.. alive on Oct. 26 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to Hypertensive Cardio Renal	
Due to Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. H. Bailey M.D. M. D. or other
Address 2019 - 11th St. NW Date signed 10/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69273

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Prince Georges

City or town Colmar Manor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

4209 Newark Road

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Colmar Manor

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4209 - Newark Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Richard David Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Elizabeth Ann Brown

6.(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) May 14, 1895

8. AGE: Years 52 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Florida (Town, county, and state)

10. Usual occupation Printer

11. Industry or business Times-Herald

FATHER 12. Name Unknown

13. Birthplace Florida

MOTHER 14. Maiden name Unknown

15. Birthplace Florida

16. Informant Elizabeth Ann Brown

Address Colmar Manor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10. 1947 (month) (day) (year)

Cemetery or crematory Arlington Cemetery

Location Va

18. Funeral director J. Gaeche Sons

Address Hyattsville Md.

19. 10/9 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1947 at 11 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner James D. Boyd M.D. or other

Address Hyattsville Md. Date signed 10-8-47


RECEIVED
OCT 13 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 L

09274

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 7 mos., 28 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 year, 7 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1122 Montello Ave., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RUFUS BROWN

3.(b) Social Security Number: 579-07-6364

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Anna Brown — 6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 29, 1915

8. AGE: Years	Months	Days	If less than one day
32	5	27	____ hrs. ____ min.

8. Birthplace: Edgefield, South Carolina
(Town, county, and state)

10. Usual occupation: Porter, Union Station

11. Industry or business: -

FATHER — 12. Name: Eligah Brown

13. Birthplace: Edgefield, South Carolina

MOTHER — 14. Maiden name: Dora Machie

15. Birthplace: Edgefield, South Carolina

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10/27/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: John J. Stewart Jr.

Address: 70 H St. N.E. Wash. D.C.

19. Oct. 27, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 26 1947, at 9:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-27 1946, to 10-26 1947 and that I last saw h... im alive on 10-26 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 10/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

30g

C9275

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos., 6 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 6 mos., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1320 - 12th St., N. W. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BROWN, VICTORIA

3. (b) Social Security Number: 578-16-0421

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Albert Brown, Deceased. Wlysses Welbourne, Common-law husband.

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 29, 1913

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
34 34	5	24		

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Messenger, War Dept., Pentagon Bldg

11. Industry or business: -

FATHER — 12. Name: Peter Ailer; 13. Birthplace: Fredericksburg, Virginia

MOTHER — 14. Maiden name: Rosa Jackson; 15. Birthplace: Orange, Virginia

16. Informant: Deceased Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 26, 1947 (month) (day) (year)

Cemetery or crematory: Family Homestead

Location: Orange Court House County, Va.

18. Funeral director: L. E. Murray & Son C. H. M.

Address: 1337-10th St. N.W. Wash. D.C.

19. Oct. 23, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 1947, at 12 40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1947 to Oct. 23 1947 and that I last saw h.. alive on Oct 23 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1yr 10 mos.
Due to	
Due to	
Other conditions: Cirrh., Early Latent	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 10/23/47

VS-A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

934

09236 230

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Prince Georges
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8615 Rhode Island Ave
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Joseph Carl Campbell

3. (b) Social Security Number 577-12-3957

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Viola C. Campbell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1882

8. AGE: Years 65 | Months 7 | Days — | If less than one day ..... hrs. ..... min.

9. Birthplace Boston, Mass
(Town, county, and state)

10. Usual occupation Watchman

11. Industry or business U.S.G.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Viola C Campbell
Address 8615 Rhode Island Ave, Berwyn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31 (month) (day) 1947 (year)
Cemetery or crematory Mt Olivet
Location Washington D.C.

18. Funeral director F Gaschos Sons
Address Hyattsville Md.

19. October 30th 1947 (Date rec'd by registrar) John D Smeltz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1947 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10 1947 to October 27 1947 and that I last saw him alive on October 27 1947

Immediate cause of death	DURATION
Chronic Myocarditis	Several Years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE W. Allen Griffith M. D. or other
Address Berwyn Md Date signed 10/27/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09277

93d

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Accokeek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George
City or town: Accokeek.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME Sarah Arthur Carlisle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Louis Carlisle
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 21 - 1874

8. AGE: Years 73 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Frederick Co. Md.
(Town, county, and state)

10. Usual occupation: Nurse.

11. Industry or business

FATHER 12. Name: Washington Mathias
13. Birthplace: Md.

MOTHER 14. Maiden name: Catherine Snyder
15. Birthplace: Md.

16. Informant: Mrs Bertha Bent
Address: Accokeek, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: OCT 11 1947 (month) (day) (year)
Cemetery or crematory: Sandy Springs
Location: Sandy Springs, Md.

18. Funeral director: W. D. Chandlee Co.
Address: 511-11th St. S.E. Wash. D.C.

19. Oct. 8, 1947 (Date rec'd by registrar) Carrie F. Campbell, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 8 1947, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 1947, to October 8, 1947 and that I last saw h.. alive on October 8, 1947

Immediate cause of death	DURATION
Cerebral hemmorhage	
Due to: Cardio-vascular disease	18 years
Due to: Hypertension	10 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A Blood M.D. (M. D. or other)
Address: La Plata, Maryland Date signed: 8 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

09278

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

63b

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4816 - Edmonston Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward R. Chisum

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Gladys M. Chisum

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): May 30, 1883

8. AGE:

Years	Months	Days	If less than one day
64			...hrs. ...min.

9. Birthplace: D. C. (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: U. S. Navy Yard.

FATHER

12. Name: Billy Chisum

13. Birthplace: D. C.

MOTHER

14. Maiden name: Mary J. Murphy

15. Birthplace: D. C.

16. Informant: Gladys Chisum

Address: 4816 Edmonston Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 15, 1947 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D. C.

18. Funeral director: J. Stallsmith Lees Co.

Address: 306 - 4½ St. N. E.

19. 10/12 1947 (Date rec'd by registrar) Amanda Mooney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12 — 1947, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1944, to Oct 12 1947 and that I last saw h... alive on Oct 11 1947

Immediate cause of death	DURATION
Uncontrolled Insufficiency	
Due to Chronic Auricular Fibrillation.	
Due to Hyperthyroidism	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: A. Dietz M.D.

M. D. or other

Address: Hyattsville, Md. Date signed: 10/[illegible]/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

162 L

oc 09279

Reg. Dist. No.

1. PLACE OF DEATH:
County: Prince Georges Co.
City or town: Laurel Sanitarium
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? June 17-47 to Oct 12-47
Hospital, Institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? 3 months 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4334 N. Charles
(If rural, give LOCATION)
2.(a) If veteran, name war: /

3.(a) FULL NAME Isaac Norris Cooper

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: (CLARA) Cora Cline Cooper
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 11 - 1860

8. AGE: Years: 87 Months: 3 Days: 1 If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Builder
11. Industry or business:

FATHER
12. Name: George W. Cooper
13. Birthplace: Balto, Md.

MOTHER
14. Maiden name: Elena Stgoude
15. Birthplace: England.

16. Informant: Raymond B. Cooper
Address: 1534 Roedde Ct

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/16/47 (month) (day) (year)
Cemetery or crematory: London Park
Location: Balto. Md.

18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.

19. Oct 14 19 47 (Date rec'd by registrar) A. W. Vedrut Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12th 19 47 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 19 47 to Oct 12 19 47
and that I last saw h. im alive on Oct 12 - 47 19 47

	DURATION
Immediate cause of death: Myocardial failure	one week
Due to: Senilita	6 Months
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jesse L. Cooper M. D. or other
Address: Laurel Md. Date signed 10/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16 10 09280

Reg. Diat. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Mitchelville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Mitchelville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James August Crouch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19 1947

8. AGE: Years	Months	Days	If less than one day
	1	13	hrs. min.

9. Birthplace D. C.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Leroy F. Crouch

13. Birthplace D. C.

MOTHER 14. Maiden name Dorothy Miller

15. Birthplace D. C.

16. Informant Leroy F. Crouch

Address Mitchelville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2 1947 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Washington D. C.

18. Funeral director J. F. & T. Lee Funeral Home

Address 300 - 4th St. N. E.

19. Oct. 2 1947 Edward J. Collins

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1947, at 5:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1947 to Oct 2 1947

and that I last saw h alive on Oct 1 1947

Immediate cause of death	DURATION
Atelectasis	12 hours
Due to Mask	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

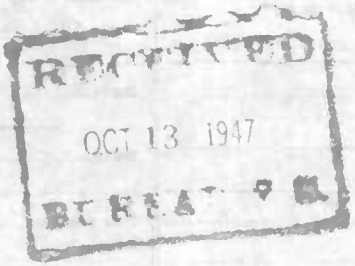
23. SIGNATURE Robert B Sasse M. D. or other

Address Upper Marlboro Date signed Oct 4 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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OCT 13 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 932

09281

Reg. Diat. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 68 days

Hospital, institution, or street address where death occurred:

Pr.Geo.Gen'l

How long in hospital or institution? 68 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr.Geo.

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4705 WOOdberry Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Cusick, Mrs. Lucretia

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 6, 1875

8. AGE: Years	Months	Days	If less than one day
72			hrs. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Milton ~~Houston~~ Houton
13. Birthplace: Va.

MOTHER
14. Maiden name: Mary Tolson
15. Birthplace: Va.

16. Informant: Mrs. Thelma Wright
Address: 4705 Woodberry Rd. Riverdale Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8 1947 (month) (day) (year)
Cemetery or crematory: St. Lincolns Cemetery
Location: Wash. Baltimore Blvd. Md.

18. Funeral director: H. H. Chambers Co.
Address: 5801 Cleveland ave. Riverdale, Md.

19. 10/4 19 47 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~10-2~~ 10-2 19 47 at 11:45p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-27 19 47 to 10-2 19 47 and that I last saw her alive on 10-2 19 47

Immediate cause of death	DURATION
Arteria. Cardiovascular disease	
Due to	
Due to	
Other conditions: Gangrene - right foot	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Floyd W Hughes MD
M. D. or other

Address: Prince George General Date signed: 10-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

09282

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 7 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 7 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 733 Deleware Avenue, S. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HENRY DICKERSON

3.(b) Social Security Number: 578-14-1002

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): April 24, 1903

8. AGE: Years	Months	Days	If less than one day
44 44	5	25	hrs. min.

9. Birthplace: Keline Co., (?) Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -

FATHER
12. Name: Richard Dickerson
13. Birthplace: ? Virginia

MOTHER
14. Maiden name: Georgie Lomax
15. Birthplace: ? Virginia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 20 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: John T. Rhine & Co.

Address: 904 - 3rd St. S.W.

19. Oct. 20, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19, 1947 at 12.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 11, 1947, to Oct. 19, 1947 and that I last saw h... living on Oct 19, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculous	10 mo.
Due to:	
Due to:	
Complications: Tuberculous enteritis	3 mo.
Other conditions: Tuberculous peritonitis	1 mo.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 10/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

09283

Reg. Dist. No. 2-45

1. PLACE OF DEATH:

County: Pro Geo County

City or town: Hyattsville Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Pro Georges Co

City or town: Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4308 Farragut St
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Charles Forrest Dickey

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bessie M. Dickey

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): August 27, 1872

8. AGE: Years	Months	Days	If less than one day
75			hrs. min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)

10. Usual occupation: President of C. F. Dickey Inc

11. Industry or business: feed and coal business

FATHER 12. Name: unknown

13. Birthplace: unknown

MOTHER 14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Mrs Bessie Dickey

Address: Hyattsville Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 21, 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Maryland

18. Funeral director: F. Gasch's Sons
F. Gasch's sons

Address: Hyattsville Md.

19. Oct 20 (Date rec'd by registrar) 1947 James Seavey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18, 1947 19 at 8.45A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 41 to 10-18 19 47 and that I last saw h. in alive on 10-17-47 19 47

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden
Due to:	
Due to: Hypertension Hypertension	10 yr
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Duncan Hays M. D. or other

Address: Hyatts. Md Date signed 10-1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09284

136

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 21 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 7 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3010 Mass. Ave., S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: JOYCE DUCKWORTH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wendall O. Duckworth

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): July 23, 1926

8. AGE: Years	Months	Days	If less than one day
21 21	2	9	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER
12. Name: Frank M. Hodge
13. Birthplace: Raleigh, North Carolina

MOTHER
14. Maiden name: Miranda E. Allen
15. Birthplace: Washington, D. C.

16. Informant: Deceased
Address

17. A Burial (Burial, cremation, or removal, Which?) Date thereof Oct 4-47 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: P.G. Co., Md.

18. Funeral director: Arthur E. Simmons Jr.

Address: 2007 Nicholson St. S. E.

19. 10/2 (Date rec'd by registrar) 1947 Rowland & Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1947 at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1947, to Oct 2 1947 and that I last saw h.. alive on Oct 2 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed 10/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09285

131a

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Prince George's

City or town: Capitol Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Capitol Hights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6115 Bass Street

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: CHARLES WESLEY EAGEN

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Grace

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): April 9th 1875

8. AGE: Years	Months	Days	If less than one day
~~73~~ 72	6	19	...hrs. ...min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: U.S. Navy Yard

FATHER 12. Name: Peter Eagen

FATHER 13. Birthplace: N.Y. City N.Y.

MOTHER 14. Maiden name: Sarah Ray

MOTHER 15. Birthplace: Washington, D.C.

16. Informant: Mrs Grace Eagen

Address: 6115 Bass St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 30-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland, Md.

18. Funeral director: J. William Lee's Sons Co.

Address: 300 J - 4th, St. N.E. Washington, D.C.

19. Oct 28 1947 (Date rec'd by registrar) Edna F. Sollers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 1947 at 4: A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Oct 28 1947 and that I last saw h.. alive on Oct 27 1947

Immediate cause of death	DURATION
Uremia	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James J. Boyd M. D. or other

Address: Forestville Md. Date signed: 10-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

931

C9286

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Deanwood Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Nine months
Hospital, Institution, or street address where death occurred: 1307 - 52nd Street
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Deanwood Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1307 - 52nd Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Thomas Willie Eugene Evans

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Almeta Evans
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1904

8. AGE: Years: 43 Months: 9 Days: If less than one day: hrs. min.

9. Birthplace: Carbon Hill, Ala. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Thomas Evans
13. Birthplace: Union Springs, Ala.

MOTHER
14. Maiden name: Jary Lee Bradley
15. Birthplace: Kennedy, Ala.

16. Informant: Mrs. Jerry Lee Evans
Address: 1307 52nd St.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 4 47 (month) (day) (year)

Cemetery or crematory:
Location: Washington D. C.

18. Funeral director: Henry W. Lewis & Co
Address: 1225 - 11th Street N.W.

19. Oct. 4 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4, 1947, at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Oct. 4, 1947
and that I last saw him alive on Oct. 3, 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertensive Cardio-Vascular Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John W. Robinson, M.D. M. D. or other
Address: 1061 Eastern Ave. N.E. Date signed: 10/4/47

VS A15 9-45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09287

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING — VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Capitol Heights Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 1/4 yrs
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Capitol Heights Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 306 - 61st St -
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Magdalena Fankhauser.

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	W	widowed

6.(b) Name of husband or wife: Gottfried Fankhauser Sr.
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 14 1863

8. AGE: Years 84 | Months — | Days — | If less than one day: hrs. min.

9. Birthplace: Switzerland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home
12. FATHER — Name: unknown Henri
13. FATHER — Birthplace: Switzerland
14. MOTHER — Maiden name: unknown
15. MOTHER — Birthplace: Switzerland
16. Informant: Louis E Long
Address: 306-61st St Capitol Heights Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 23-1947 (month) (day) (year)
Cemetery or crematory: Prospect Hill
Location: Washington, Dc
18. Funeral director: W. W. Chambers Co.
Address: 517 11th St. S.E.
19. Oct. 21 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20 19 47, at 10 25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 19 47, to Oct 20 19 47 and that I last saw h. ex alive on Oct 20 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	4 hrs
Due to: General Arterio — Sclerosis	Unknown
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Natural
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: Louis C Von Gatten M. D. or other
Address: Washington, Dc Date signed: Oct 20 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13b

09288

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH

County PRINCE GEORGE

City or town MARYLAND PARK MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo.

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PRINCE GEORGE County Md.

City or town MARYLAND PARK.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6503. DAVIS ST

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ELLEN. LOUISE. GIBSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED.

6.(b) Name of husband ~~or wife~~ ROY. M. GIBSON.

MARCH. 28. 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 28th 1923

8. AGE: Years	Months	Days	If less than one day
24			hrs. min.

9. Birthplace WASHINGTON D.C. (Town, county, and state)

10. Usual occupation HOUSE WIFE.

11. Industry or business

FATHER 12. Name HERMAN. BALDERSON.

13. Birthplace VA.

MOTHER 14. Maiden name VIOLA. GREENWELL

15. Birthplace WASHINGTON D.C.

16. Informant MR ROY M. GIBSON

Address 6503 Davis St. Md. Pk. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-10-47 (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington Va.

18. Funeral director A.W. Chambers Co.

Address 517 11th St S.E.

19. 10-10 19 47 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 19 47, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/15 19 46 to Oct. 5. 19 47

and that I last saw her alive on 10/5/47 19

Immediate cause of death Pulmonary tbc. — DURATION: 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jerry J. Hadley M.D. M. D. or other

Address 1252 [illegible] Rd Date signed 10-7-47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

09284
Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos., 14 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 4 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1018 D. St., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MURLL GOULDING

3.(b) Social Security Number: 577-28-7934

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Daphne E. Goulding
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): May 27, 1893

8. AGE: Years	Months	Days	If less than one day
54	4	15	..... hrs. ..... min.

9. Birthplace: Detroit, Michigan
(Town, county, and state)
10. Usual occupation: Cashier
11. Industry or business: -

FATHER
12. Name: Sam Goulding
13. Birthplace: London, England

MOTHER
14. Maiden name: Florence Beane
15. Birthplace: Waterford, Virginia

16. Informant: Deceased
Address

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 10 13 47 (month) (day) (year)
Cemetery or crematory: WASHINGTON NATIONAL
Location: PRINCE GEORGE COUNTY, Md

18. Funeral director: W. W. Chambers Co.
Address: 517-11th St. S. E.

19. Oct 12, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 12 19 47 at 6:25A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 27 19 47, to OCT. 12 19 47
and that I last saw h... in alive on Oct 12 19 47

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	10 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 10/12/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

09290

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos., 15 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 8 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 37 R. St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES. GRAHAM.

3.(b) Social Security Number: 242-03-4100

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Gracie Lee

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): March 30, 1916

8. AGE: Years	Months	Days	If less than one day
31 31	6	2	hrs. min.

9. Birthplace: Maiden, North Carolina
(Town, county, and state)

10. Usual occupation: Freight Work

11. Industry or business: -

FATHER
12. Name: Henry Graham
13. Birthplace: ?

MOTHER
14. Maiden name: Ellen Brooks (Graham)
15. Birthplace: ?

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 3, 1947 (month) (day) (year)

Cemetery or crematory

Location: to Maiden, N. C.

18. Funeral director: James A. Davis
Address: 142 North St. Balto. Md

19. Oct. 2, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2nd 1947, at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16th 1947, to Oct 2nd 1947, and that I last saw living alive on Oct 2nd 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 10/2/47

VS A15 9-45 16M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 e

09291

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Prince George Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Fulton
(If outside city or town limits, write RURAL and give nearest town)
Street No. R 7 D
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harding Mr Charles H.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/1882

8. AGE:

Years	Months	Days	If less than one day
65	8		hrs. min.

9. Birthplace Fulton, Md.
(Town, county, and state)
10. Usual occupation farmer
11. Industry or business
FATHER 12. Name William Fulton
13. Birthplace Md.
MOTHER 14. Maiden name Carolyn Yager
15. Birthplace Md.
16. Informant Ethel Judy - sister
Address Fulton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10 1947 (month) (day) (year)
Cemetery or crematory Fulton Md
Location St Pauls Cemetery
18. Funeral director J Arthur Walters
Address 505 Wash. Blvd. Laurel, Md.
19. Oct 8 1947 (Date rec'd by registrar) James Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8-47 19 8:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-2-8 19 to 10-8 19 47
and that I last saw him alive on 10-8-47 19
Immediate cause of death Carcinoma of Cecum — DURATION 3 mos.
Due to
Due to Pulmonary embolism
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Inoperable carcinoma
Date of op. 10/4/47
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel A Nickell M D
M. D. or other
Address 1746 K St NW Wash DC Date signed 10/8/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C9292

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred: Maryland Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo. Co.
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward Lee Harman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Edna M Harman
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 16, 1887

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
60	2	29		

9. Birthplace: Bowie Maryland (Town, county, and state)
10. Usual occupation: Track Foreman
11. Industry or business: Pennsylvania R.R. Co.

FATHER
12. Name: Orrin Harman
13. Birthplace: Bowie Md.

MOTHER
14. Maiden name: Rachel Neary
15. Birthplace: Bowie Md.

16. Informant: Mrs. Edna M Harman
Address: Bowie Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 18, 1947 (month) (day) (year)
Cemetery or crematory: Trinity Cemetary
Location: Patuxent, Maryland

18. Funeral director: DeWitt Donaldson
Address: Laurel, Maryland

19. Oct 18 47 (Date rec'd by registrar) M. Blackmore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15 1947 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 9 1947 to Oct 15 1947 and that I last saw h[illegible] alive on Oct 15 1947

Immediate cause of death: Apoplexy — DURATION: 1 Mo
Due to: R. Hemiplegia — 5 Yrs.
Due to: Arteriosclerosis Hypertension
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J M Warren M.D. M. D. or other
Address: Laurel Date signed: 10/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83w

09293

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3days.

Hospital, Institution, or street address where death occurred: Leland Memorial Hospital.

How long in hospital or Institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Brentwood (If outside city or town limits, write RURAL and give nearest town)

Street No. 3707 Taylor St. (If rural give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Miss Lydia Haskell

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single.

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 26, 1869

8. AGE: Years 78 | Months 3 | Days 8 | If less than one day: hrs. min.

9. Birthplace: Illinois (Town, county, and state)

10. Usual occupation: retired government worker clerk.

11. Industry or business:

FATHER — 12. Name: Joel Haskell

FATHER — 13. Birthplace: new york.

MOTHER — 14. Maiden name: Mary Ammia ?

MOTHER — 15. Birthplace:

16. Informant: Mrs. M. K. Stephens

Address: niece.

17. (Burial, cremation, or removal. Which?) Cremation Date thereof 10-7-47 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location: Wash-Balto Blvd & D.C. Line

18. Funeral director: Wm. J. Malloy

Address: 3200 R.I. Ave. Mt. Rainier Md.

19. Oct 7 1947 (Date rec'd by registrar) James Seavey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5 1947 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 10 1947 to Oct. 5 1947 and that I last saw h.er alive on October 4 1947

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	25 days.
Due to: Hypertension and Generalized Arteriosclerosis	
Due to:	
Other conditions: TERMINAL BRONCHOPNEUMONIA	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: David L. Clayman M.D. M.D. or other

Address: Mt. Rainier, Md. Date signed: 10-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

C9294

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

Reg. Dist. No. 231

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Geo. Co.
County Pr. Geo. Co.
City or town Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr. Geo. Co
City or town Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4029 Bladensburg Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rozila L. Hubbard

3.(b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: Geo. H. Hubbard
6.(c) If alive, give age 41 years
7. Birth date of deceased (mo., day, yr.): Aug-7-1860

8. AGE: Years 87 Months 2 Days 15 If less than one day ... hrs. ... min.

9. Birthplace: Cincinnati, Ohio
(Town, county, and state)
10. Usual occupation: Practical Nurse
11. Industry or business

FATHER
12. Name: Alcander Lovejoy
13. Birthplace: unknown

MOTHER
14. Maiden name: Zelie Mathieu
15. Birthplace: unknown

16. Informant: Mrs Zelie Mae Cook
Address: 4029 Bladensburg Rd

17. Burial Date thereof 10/25/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Wash. D.C.

18. Funeral director: W W Chambers Co
Address: Riverdale, Md

19. 10/23 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1947, at 4:30 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 27 1947, to Oct 22 1947
and that I last saw her alive on Oct. 22 1947

	DURATION
Immediate cause of death: Arterio sclerotic heart and kidney disease	
Myocardial decompensation	Sept. 27-47
Due to: Senile	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) No
Means of injury Injured at work? No

23. SIGNATURE George Hagearge M. D. or other
Address 3717 - 33rd Ave Date signed 10/22/47

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 8 [illegible]5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince George

City or town Hyattsville - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred

Mother Joes Rest Home

How long in hospital or institution? 5 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia Washington

City or town 5308 Rhode Island Ave N.E.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mida Herling

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 31, 1866

8. AGE:

Years	Months	Days	If less than one day
81	8	2	..... hrs. ..... min.

9. Birthplace Rockville Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name unknown

FATHER 13. Birthplace unknown

MOTHER 14. Maiden name Mida Allen

MOTHER 15. Birthplace Rockville Maryland

16. Informant Hospital Records

Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct 6 1947 (month) (day) (year)

Cemetery or crematory Congressional Cemetery

Location Washington D.C.

18. Funeral director The L.P.B. Hines Co

Address 2901 14th St. N.W.

19. Oct 3 1947 (Date rec'd by registrar) James Sevy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1947 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 3 1947

and that I last saw her alive on Oct 2 1947.

Immediate cause of death	DURATION
Chr Dig. Myocarditis.	30 days
Due to Decompensation	2 days
Due to Gen Arteriosclerosis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard T Morse M.D.

Address 28 Carroll Ave, Takoma Park, Md. M. D. or other Date signed 10/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

09296

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 1/2 years.
Hospital, Institution, or Home in which death occurred:
3507 Kennedy Street.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3507 Kennedy Street.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Emma Lela Hutchinson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife William T. Hutchinson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 13, 1856.

8. AGE: Years	Months	Days	If less than one day
90	11	29	..... hrs. ..... min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business

FATHER
12. Name James E. Batelor
13. Birthplace Washington D. C.

MOTHER
14. Maiden name Henrietta A Batelor
15. Birthplace Washington, D. C.

16. Informant W. E. Hutchinson
Address 4214 Jefferson St. Hyattsville

17. (Burial, Cremation, or Removal? Which?) Burial Date thereof Oct 14 1947 (month) (day) (year)
Cemetery or crematory Glenwood
Location Washington D C

18. Funeral director F Gadsby Sons
Address Hyattsville md

19. Oct 13 1947 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1947 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 1947 to Oct 11 1947
and that I last saw h alive on Oct 11 1947

Immediate cause of death	DURATION
Fracture neck of femur (Rt)	8 days
Due to	
Due to	
Other conditions Shock, HBP (230/100)	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Oct 3/47
Where did injury occur? Home, 3507 Jefferson Hyattsville Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) home
Means of injury fell down stairs & broke neck Injured at work?

23. SIGNATURE W. E. Hutchinson M. D.
M. D. or other
Address 4214 Jefferson Hyattsville Date signed Oct 14/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

74a

09297

Reg. Dist. No. 234

1. PLACE OF DEATH:

County: Prince George

City or town: Clinton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Clinton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James T. Irby

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lola May Irby

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 24th 1912

8. AGE: Years	Months	Days	If less than one day
34			..... hrs. ..... min.

9. Birthplace: Penn. County, Virginia (Town, county, and state)

10. Usual occupation: Maintenance Man

11. Industry or business: Bergman Laundry

FATHER — 12. Name: Luther H. Irby

13. Birthplace: Va.

MOTHER — 14. Maiden name: Rosa Switzland

15. Birthplace: Va.

16. Informant: Mrs. Lola May Irby

Address: Clinton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 8th 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland, Maryland

18. Funeral director: Arthur E. Simmons Jr.

Address: 2007 - Nichols Ave S E Wash. D. C.

19. Oct. 6th 1947 (Date rec'd by registrar) Edward J Beach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5, 1947, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June. 1946, to Oct. 5 1947 and that I last saw h.. alive on Oct. 4 1947

Immediate cause of death	DURATION
Lymphatic leukemia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Alan Artyman M. D. or other

Address: 2015 - Nichols Ave. S E. Date signed: Oct. 6, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09298

136

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 26 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 929 New Jersey Avenue, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: IRVING EMMA D.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Amos Irving

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): October 18, 1900

8. AGE: Years	Months	Days	If less than one day
46	11	18	hrs. min.

9. Birthplace: Edgefield, South Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER
12. Name: Elbert Griffin
13. Birthplace: Edgefield, South Carolina

MOTHER
14. Maiden name: Virginia Slaughter
15. Birthplace: Edgefield, South Carolina

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10/7/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: Malone & Schey Inc.

Address: 424-R ST N.W.

19. Oct. 7, 1947 (Date rec'd by registrar) Rowland & Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6, 1947, at 9:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/21 1947, to 10/6 1947, and that I last saw h[illegible] alive on 10/6 1947.

Immediate cause of death	DURATION
pulmonary tuberculosis	5 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

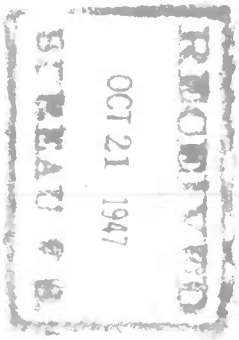
*23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 10/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15



MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09299

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate of death clearly and legibly is especially important. Physicians please write the cause

1. PLACE OF DEATH:

County: Prince George's General Hospital

City or town: Cheverly, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days and 16 hrs.

Hospital, institution, or street address where death occurred: Prince George's General Hospital

How long in hospital or institution? 6 days and 16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4906-40th Place

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME

KEIR, MR. ALFRED

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 21, 1871

8. AGE:

Years	Months	Days	If less than one day
75	11	9	hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: James Keir

13. Birthplace: England

MOTHER — 14. Maiden name: Elizabeth Kay

15. Birthplace: England

16. Informant: Mrs Emma Keir

Address: Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?): Burial Date thereof: Nov 1, 1947 (month) (day) (year)

Cemetery or crematory: Ft Lincoln

Location: Washington DC

18. Funeral director: F Gascho sons

Address: Hyattsville Md.

19. 11/1 1947 (Date rec'd by registrar) Amanda Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30 1947 at 5 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 30 1947

and that I last saw h alive on Oct 29 1947

Immediate cause of death	DURATION
Cardiac failure	
Due to: Cardiac thrombosis	
Due to: do	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: do

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo H Demarr M.D. M. D. or other

Address: Hyattsville Md Date signed: Oct 30 '47

09300

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

480

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: PRINCE GEORGE

City or town: LANHAM (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Mo.

~~Hospital, Institution~~ or street address where death occurred: RIVERDALE ROAD

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: PRINCE GEORGE

City or town: LANHAM (If outside city or town limits, write RURAL and give nearest town)

Street No.: RIVERDALE ROAD. (If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3.(a) FULL NAME: (DIXIE) ETHEL KING

3.(b) Social Security Number: UNKNOWN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	DIVORCED

6.(b) Name of husband ~~or wife~~: UNKNOWN

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): MARCH 2nd, 1913

8. AGE: Years	Months	Days	If less than one day
34	7	20	..... hrs. ..... min.

9. Birthplace: LAWRENCE COUNTY, KY. (Town, county, and state)

10. Usual occupation: GOV'T EMPLOYEE

11. Industry or business

FATHER

12. Name: JAMES KING

13. Birthplace: KENTUCKY

MOTHER

14. Maiden name: MARTHA CASTLE

15. Birthplace: KENTUCKY

16. Informant: E. J. KING

Address: RIVERDALE ROAD – LANHAM, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/24/47 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Wash. D.C.

18. Funeral director: C. W. Chamberlain Co.

Address: 5801 - Cleveland Ave - Riverdale, Md.

19. 10/23 1947 Amanda Downey Registrar

(Date rec'd by registrar) 10-23-47 - Mrs Jack Bennett

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-22 1947, at 10:A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-7 1947, to 10-21 1947

and that I last saw her alive on 10-21 1947

Immediate cause of death	DURATION
(Carcinoma of the uterus)	
Uremia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Keith Cromer M.D. M. D. or other

Address: 1861 D St. Date signed: 10/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09301

Reg. Dist. No. 234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Clinton, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James T. King

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Rosa Lee Eldeen
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years	Months	Days	If less than one day
80			hrs. min.

9. Birthplace: Brandywine, Md (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business:
FATHER 12. Name: John King
13. Birthplace: Dont Know
MOTHER 14. Maiden name: Dont Know
15. Birthplace: Silver Hill, Md
16. Informant: Sanders King
Address: Clinton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26-47 (month) (day) (year)
Cemetery or crematory: Oakland Cem.
Location: Waldorf Md.
18. Funeral director: Arnett & Pyon
Address: Waldorf Md
19. Oct. 25 1947 Mrs. Alton Davis (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 1947 at 9 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945, to Oct 23 1947 and that I last saw him alive on Oct 23 1947

	DURATION
Immediate cause of death: Chronic Myocarditis &	4 years
Due to: Carcinoma of lip	1 Year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John E Bowes M D
M. D. or other
Address: Brandywine, Md Date signed: Oct 23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09302

96

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Pro George's Co.
City or town: Cheverly Mpl.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: 5305 Emerson st
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hyattsville Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Kraft

3. (b) Social Security Number

4. Sex: female | 5. Color or race: white | 6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: John L. Kraft

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): sept 10, 1898

8. AGE: Years: 49 | Months: 1 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: New Jersey (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Peter Fitzpatrick
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Healy
15. Birthplace: Ireland

16. Informant: John L. Kraft
Address: Hyattsville Md.

17. Disposition: transportation (Burial, cremation, or removal. Which?) Date thereof: oct 20, 1947 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: N. Arlington New Jersey

18. Funeral director: F. Gaccia Sons
Address: Hyattsville Md.

19. Oct 20, 1947 (Date rec'd by registrar) Amanda W. Rooney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19, 1947, at 1 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14, 1947, to October 18, 1947
and that I last saw h-- alive on October 18, 1947

	DURATION
Immediate cause of death: Intracranial hemorrhage at base of brain	8 days
Due to: possible ruptured aneurysm of basilar artery	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L. Louis Mendel, M.D. (M. D. or other)
Address: College Park, Md. Date signed: 10/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136

09303

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Price Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 5 mos., 22 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 5 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3910 Burns Place, S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LITTRELL, ROSE M.

3.(b) Social Security Number: 579-18-1252

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Lincoln S. Littrell

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): December 22, 1917

8. AGE: Years	Months	Days	If less than one day
29	9	23	....hrs. ....min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER — 12. Name: Thomas H. Payne

13. Birthplace: Galveston, Texas

MOTHER — 14. Maiden name: Rose E. Rabe

15. Birthplace: Washington, D. C.

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 15 1947 (month) (day) (year)

Cemetery or crematory

Location: to Washington, D.C.

18. Funeral director: Lowe-Chambers Co

Address: 517 - 11 S.E.

19. Oct. 15 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15 1947, at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1946 to Oct. 15 1947 and that I last saw her alive on Oct. 15 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr. 7 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 10/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09304

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges Co
City or town Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr Geo Co
City or town Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5413 Quintanna st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur Jacob Maldeis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marion Maldeis
6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) March 5, 1880

8. AGE: Years 67 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation Painter
11. Industry or business

FATHER
12. Name Herman Maldeis
13. Birthplace Germany

MOTHER
14. Maiden name unknown
15. Birthplace Germany

16. Informant Marion Maldeis
Address Riverdale Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29 1947 (month) (day) (year)
Cemetery or crematory Ft Lincoln
Location Washington D.C.
18. Funeral director F. Gaeta's Sons
Address Hyattsville Md.
19. Oct 27 1947 (Date rec'd by registrar) James Seavy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27, 1947 at 10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-20-44 to 10-27-47 and that I last saw h.i.m. alive on 10-27-47

Immediate cause of death	DURATION
Coronary Thrombosis	2 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John P. Clum M.D.
M. D. or other
Address Hyattsville Md Date signed 10-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

934 09305

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4310 Emerson st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Ella Mattingly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Eugene A. Mattingly.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug 14. 1873

8. AGE: Years 74 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Pa. (Town, county, and state)
10. Usual occupation: housewife.
11. Industry or business

FATHER
12. Name: Alfred Cooke
13. Birthplace: Pa

MOTHER
14. Maiden name: Alberta Rogers
15. Birthplace: Pa.

16. Informant: James Carr
Address: Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 9, 1947. (month) (day) (year)
Cemetery or crematory: Glenwood
Location: Washington D.C.

18. Funeral director: F. Gleason sons
Address: Hyattsville Md

19. Oct 8 '47 (Date rec'd by registrar) Mrs. Jas Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10 1945, to Oct 6 1947
and that I last saw h— alive on Oct 3 1947

Immediate cause of death	DURATION
Myocardial Insufficiency	
Myocardial degeneration	
Due to: Generalized Arteriosclerosis.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Calvert W. H.
M. D. or other
Address: Hyattsville Md Date signed 10-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

09306

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince George's

City or town Laurel - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 hours

Hospital, Institution, or street address where death occurred:

307 Prince George ST.

How long in hospital or Institution Warren Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince Georges

City or town Barbersville - Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rurel, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Boy McGowan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9 - 1947

8. AGE: Years | Months | Days | If less than one day: 1/15 hrs. min.

9. Birthplace Warren Hospital LAUREL, PR. GEOS. MD. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER

12. Name Clenard McGowan

13. Birthplace Catlett - Virginia

MOTHER

14. Maiden name Dorothy Tavenner

15. Birthplace Leesburg - Virginia

16. Informant Clenard McGowan

Address Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 9 1947 (month) (day) (year)

Cemetery or crematory Ivy Hill

Location Laurel, Md.

18. Funeral director Herbert Hamilton

Address Laurel, Md.

19. Oct 9 19 47 M. Brashears Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 8 19 47 at 6 30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10 8 19 47 to 10 9 19 47

and that I last saw h alive on 10 9 19 47

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B A Warren M. D. or other

Address Oct 9 - 1947 Laurel Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct code is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

138 09307

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 26 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 month, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 62 W. St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BESSIE B. MELTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edward R. Melton
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): February 11, 1882

8. AGE: Years	Months	Days	If less than one day
65	8	14	hrs. min.

9. Birthplace: Richmond, Virginia (Town, county, and state)
10. Usual occupation: Clerk in War Department
11. Industry or business: - - -

FATHER
12. Name: Sydney Puckett
13. Birthplace: Richmond, Virginia

MOTHER
14. Maiden name: Anna F. Gill
15. Birthplace: Richmond, Virginia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 25, 1947 (month) (day) (year)
Cemetery or crematory
Location: to Washington, D.C.
18. Funeral director: Deal Funeral Home
Address 4812 Ga ave. N.W. Wash. D.C.

19. Oct 25, 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25, 1947, at 11 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/28 1947 to 10/25 1947 and that I last saw h[illegible] alive on 10/25 1947

Immediate cause of death: pulmonary tuberculosis — DURATION: 7 mos.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md., Date signed 10/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09308

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred: Glenn Dale ~~939 F. Street, S. W. Washington~~

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 939 F. St., S. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MELVIN MOXLEY

3.(b) Social Security Number: 578-12-8701

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 19, 1913

8. AGE: Years	Months	Days	If less than one day
34 34	1	7	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: –

FATHER
12. Name: Walter Moxley
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Eva Jane Smith
15. Birthplace: Washington, D. C.

16. Informant: Deceased
Address

17. (Burial, cremation, or removal. Which?) Removal Date thereof 10/27/47 (month) (day) (year)

Cemetery or crematory: To Washington, D.C.

Location

18. Funeral director: J. Copeland
Address 423-4th St. N.W.

19. (Date rec'd by registrar) Oct. 27, 1947 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 26 1947, at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7, 1947, to Oct. 26 1947 and that I last saw h. l. m. alive on Oct. 26 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	1 yr. 2 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 10/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09309

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Prince George's General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: 6204 Lombard ST.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Cheverly, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Newman, Edith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 23- 1890

8. AGE: Years	Months	Days	If less than one day
77	1	26	..... hrs. ..... min.

9. Birthplace: Massachusetts (Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER — 12. Name: John Blaisdell

13. Birthplace: Mass

MOTHER — 14. Maiden name: Emily Deering

15. Birthplace: Maine

16. Informant: Hospital records

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Oct 21 1947 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location: Washington D.C.

18. Funeral director: F. Gabler Sons

Address: Hyattsville Md.

19. Oct 19 '47 (Date rec'd by registrar) Amanda Deeney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-18 1947, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1946 to Oct. 18 1947 and that I last saw h-er alive on 10-17 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	10 min.
Due to Chronic Myocarditis & Coronary Insufficiency	3 mo.
Due to Diabetes Mellitus	25 yrs.
Other conditions Severe Chronic Pain in (Phantom Pain) Stump of Amputated left leg	13 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Lumbar Sympathectomy for Phantom Pain in Left Date of op. 6-27-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W Bruger M.D. (M. D. or other)

Address: Mt. Rainier Md. Date signed 10-18-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
OCT 23 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09310

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's General Hospital

City or town: Cheverly, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 hrs.

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 11 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Bowie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Boy Randolph

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1947

8. AGE:

Years	Months	Days	If less than one day
0	0	0	11 hrs. ..... min.

9. Birthplace: Prince George's General Hospital

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Pittman Randolph

13. Birthplace: Md.

MOTHER

14. Maiden name: Inez Kreitzer

15. Birthplace: Md.

16. Informant: Hospital Records

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 10/18/47 (month) (day) (year)

Cemetery or crematory: Prince Georges General Hospital

Location: Cheverly, Md.

18. Funeral director: G. R. Bealy, Supt.

Address: Cheverly, Md.

19. 10/20 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12, 1947, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 1947 to Oct 12 1947 and that I last saw him alive on Oct 12 1947

Immediate cause of death	DURATION
Immature birth 8 mo. Lived ½ day.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Robert S. McElroy M.D. M. D. or other

Address Summit, Md. Date signed 10/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09311

Reg. Diat. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ days

Hospital, institution, or street address where death occurred: Prince George's Gen. Hosp

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Berwyn Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5805 Ruatan St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 1

3.(a) FULL NAME: WILLIAM B. RIDGWAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary A. Ridgway

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4th 1891

8. AGE: Years	Months	Days	If less than one day
56	3	20	..... hrs. ..... min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Steam fitter

11. Industry or business: Construction

FATHER — 12. Name: Hayden Ridgway

FATHER — 13. Birthplace: Washington D. C.

MOTHER — 14. Maiden name: Mary Jane Dove

MOTHER — 15. Birthplace: Washington D. C.

16. Informant: Mary A. Ridgway

Address: 5805 Ruatan St., Berwyn Hgt's Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27, 1947 (month) (day) (year)

Cemetery or crematory: Washington Natl. Cemetery

Location: Suitland Road, Maryland

18. Funeral director: M. W. Chambers Co

Address: Riverdale, Md.

19. Oct 26 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 1947 at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed chest	
Due to: Fracture of the skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 10/22/47

Where did injury occur? Hyattsville P. G. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Rhode Island Ave

Means of injury Pedestrian struck by a street car Injured at work?

Deputy Medical Examiner

23. SIGNATURE: James D. Boyd M.D. or C.M.E.

Address: Forestville, Md. Date signed 10/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

09312

S 245 Reg. Diat. No.

1. PLACE OF DEATH:

County Prince George

City or town River Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2606 Rhode Island Ave

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Rollins, Mrs. Mamie Agnes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Edwin Carlton Rollins

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) August 23, 1879

8. AGE:

Years	Months	Days	If less than one day
68	1	14	..... hrs. ..... min.

9. Birthplace Norfolk, Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Patrick Lynch

13. Birthplace Ireland

MOTHER

14. Maiden name Ella Ellsworth Ellis

15. Birthplace Boston, Mass.

16. Informant Wallace R. Lee K. (son-in-law)

Address 2606 Rhode Island Ave N.E. Washington, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 7 1947 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Washington D.C.

18. Funeral director J. W. McLeod Sons

Address 300-4th St NE

19. Oct 7 1947 (Date rec'd by registrar) James Seney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1947 at 6 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4 1947 to Oct. 7 1947 and that I last saw h.er alive on October 7 1947

	DURATION
Immediate cause of death Anemia (a) 131	1 wk
Due to Chronic glomerular nephritis	?
Due to Arteriosclerotic hypertensive heart disease	?
Other conditions Rupt hy Dothorax	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. A. Schaffenberg, Jr. M.D. M. D. or other

Address 4404 Lawrenceburg Rd., Riverdale, Md. Date signed 10/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13b

09313 93124

CERTIFICATE OF DEATH

Reg. Dist. No. ..... C. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Lanham P.O. - Vista, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Lanham P.O. - Vista, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ruth Mae Russell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Married

6.(b) Name of husband ~~or wife~~: Clarence A. Russell

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): July 27, 1907

8. AGE: Years: 40 | Months: 2 | Days: 14 | If less than one day: ___ hrs. ___ min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)

10. Usual occupation: Clerk grocery Store

11. Industry or business: Store

FATHER — 12. Name: William Priestastea

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Martha L. Henderson

MOTHER — 15. Birthplace: Virginia

18. Informant: Martha L. Henderson Mother

Address: Lanham P.O. Vista md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14, 1947 (month) (day) (year)

Cemetery or crematory: Lincoln Memorial Cem.

Location: Md.

18. Funeral director: R. N. Horton

Address: 1322 Yan st. NW.

19. 10/11 1947 (Date rec'd by registrar) Amanda Downey Registrar

10-14-47 Mrs Jack Bennette

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1947 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 1947 to Oct. 11, 1947

and that I last saw her alive on Oct. 9 1947

Immediate cause of death: Chronic Pulmonary Tuberculosis — DURATION: 4 yrs

Due to: — DURATION:

Due to: — DURATION:

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Previously treated in Treatment Hosp. Wash. D.C.

23. SIGNATURE: Wm. H. Gill M. D. (M. D. or other)

Address: Brentwood, Md. Date signed: 10-11-47

9527

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Diat. No. 339

1. PLACE OF DEATH:

County Pr. George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 85 yrs

Hospital, institution, or street address where death occurred:

Warren Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. Montgomery Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Thomas Scott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife Annie L. Scott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 18, 1862

8. AGE: Years 85 Months 4 Days 12 If less than one day ..... hrs. ..... min.

9. Birthplace Laurel Pr. Geo. Maryland (Town, county, and state)

10. Usual occupation Retired train dispatcher

11. Industry or business B. & O. Railroad

FATHER 12. Name Charles Scott

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Mary Virginia ?

MOTHER 15. Birthplace Virginia

16. Informant Mrs. Nancy L. Allen

Address 380 Main St. Laurel Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 1, 1947 (month) (day) (year)

Cemetery or crematory Ivy Hill Cemetery

Location Laurel, Maryland

18. Funeral director Mc Will Donaldson

Address Laurel, Maryland

19. Nov 1 1947 F. M. Beckwith Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1947 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1947 to Oct 30 1947

and that I last saw him alive on Oct 30 1947

	DURATION
Immediate cause of death Terminal Pneumonia	2 days
Due to Cerebral Hemorrhage	3 days
Due to Hypertension	-
Other conditions Arteriosclerosis Diabetes Mellitus	-

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. M. Warren M.D.

M. D. or other

Address Laurel Md. Date signed 10/31/47

NFADING INK. Supply every item of information carefully. The correct age tant. Physicians: please write the causes of death clearly and legibly.

09314

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Pr George
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: Mother Jones Rest Riggs Road
How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr George
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Riggs Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Elizabeth Shaw.

3.(b) Social Security Number:

4. Sex: fem
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: John Shaw. Deceased.
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): March 22, 1863
8. AGE: Years: ~~87~~ 84 Months: 7 Days: 5 If less than one day: ____ hrs. ____ min.
9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Keeper wife
11. Industry or business: Same
FATHER 12. Name: Thomas Bellew
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Margret Hawley
MOTHER 15. Birthplace: Ireland
16. Informant: Mrs. Marie Hutchins
Address: 3419 22nd St. N.E.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Bladensburg Rd. N.E. Washington, D.C.
18. Funeral director: J. Arthur Walters
Address: 254 Carroll St. Takoma Park. D.C.
19. ____ 19____ (Date rec'd by registrar) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27 1947, at 8 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1947, to Oct 27 1947 and that I last saw h... alive on Oct 23 1947

	DURATION
Immediate cause of death: Cerebral Thrombosis	10/19/47
Due to: Gen Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Howard Thurman M. D. or other
Address: 22 Carroll ave Takoma Park Md. Date signed: 10/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09315

1310

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH: County: Prince George's; City or town: Berwyn (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 20 yrs; Hospital, institution, or street address where death occurred: 5100 Berwyn Rd; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Maryland; County: Prince George's; City or town: Berwyn (If outside city or town limits, write RURAL and give nearest town); Street No.: 5100 Berwyn Rd (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Louise Smith

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Amos Curtis Smith

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): 11 March 1872

8. AGE: Years	Months	Days	If less than one day
75	6	25	— hrs. — min.

9. Birthplace: Fredericksburg, Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER — 12. Name: James Jones; 13. Birthplace: Fredericksburg, VA

MOTHER — 14. Maiden name: Dorothy Akers; 15. Birthplace: Fredericksburg, VA.

16. Informant: Mrs Dorothy Neitzey; Address: 5100 Berwyn Rd Berwyn

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8 1947 (month) (day) (year)

Cemetery or crematory: Forest Lawn Cemetery

Location: Washington D.C.

18. Funeral director: M W Chambers Co

Address: Riverdale Md

19. Oct 7 (Date rec'd by registrar) 19 47 James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 October 1947 at 6 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 46 to October 19 47 and that I last saw her alive on 5 October 19 47

Immediate cause of death	DURATION
Hypostatic Pulmonary Congestion	1 hr
Due to: Chronic Myocarditis	
Due to: Hypertensive Cardio Vascular Renal Disease	15 yr
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No Operation — Date of op.:

Autopsy results: No Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C L Etienne M. D.

Address: Berwyn, Md Date signed: 6 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09316

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County 4210 29th St. - Pr. Geo.
City or town Mt. Rainier, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4210 29th St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Wm. A. Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Annie M. Smith
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) October 7, 1872

8. AGE: Years 75 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Chas. A. Smith
13. Birthplace Virginia

MOTHER
14. Maiden name Mollie Taylor
15. Birthplace Virginia

16. Informant Wm. M. Smith - Son
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 14th 1947 (month) (day) (year)
Cemetery or crematory F.H. Lincoln
Location Wash. Balto. Blvd + D.C. Line Md.
18. Funeral director Wm. J. Malley
Address 3200 R.I. Ave. Mt. Rainier Md.

19. Oct 13 1947 (Date rec'd by registrar) James Seary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1947 at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 28 1947 to October 12 1947 and that I last saw him alive on October 11 1947

Immediate cause of death — DURATION
Generalized Carcinomatosis — ?
Due to
Carcinoma of Prostate
Due to
Other conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations Cancer of Prostate Date of op. Nov. 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. S. Clayman, MD M. D. or other
Address Mt. Rainier, Md. Date signed 10/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

09317

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: University Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, institution, or street address where death occurred:
6504 - 40th Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: University Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6504 - 40th Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Irene Rist Snyder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Rudolph Snyder
6.(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): January 3, 1882

8. AGE: Years: 65 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Fort Collins, Colorado
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: William Rist
13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Unknown
15. Birthplace: Texas
16. Informant: Rudolph Snyder
Address: University Park, Md.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof Oct 28 1947 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Washington D.C.
18. Funeral director: E. Gaddis Sons
Address: Hyattsville Md.
19. Oct 24 1947 (Date rec'd by registrar) Jane Serr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 1947, at 8:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner James J. Boyd M. D. or other
Address: Hyattsville Md. Date signed 10-27-47

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09318

161 C 8

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred: Prince George General Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: Arlington

City or town: Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2101 Fillmore

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

~~BABY~~ ~~BOY~~ SWANNER, Frank Clifton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 30, 1947

8. AGE:

Years	Months	Days	If less than one day
0	0	13	hrs. min.

9. Birthplace: Prince George's General Hospital

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER

12. Name: James Swanner

13. Birthplace: [illegible]

MOTHER

14. Maiden name: Virginia Doyle

15. Birthplace: Fla

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Md

Location: Colmar Manor Md

18. Funeral director: F Gaschy Sons

Address: Hyattsville Md

19. 10/13 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12, 1947, at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28 1947 to Oct 12 1947 and that I last saw him alive on Oct 12 1947

Immediate cause of death	DURATION
Erythroblastosis Neonatorum	12 days.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John J. Maloney M.D. M. D. or other

Address: Cheverly Md Date signed: 10-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09319

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Prince George

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years.

Hospital, institution, or street address where death occurred:

1100 Hayward Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1100 Hayward Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: LAURA JANE SWINGLE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 31, 1863

8. AGE: Years: 84 | Months: 8 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Mount Cobb, Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: Andrew Swank

13. Birthplace: Mt. Cobb. Pa.

MOTHER

14. Maiden name: Margaret Spangenberg

15. Birthplace: Mt. Cobb. Pa.

16. Informant: Mr. Stanley DePew

Address: 3r Hackney, Takoma Park. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 15, 1947 (month) (day) (year)

Cemetery or crematory: Corty Cemetery

Location: Scranton, Penna

18. Funeral director: J. Arthur Walters

Address: 754 Carroll St. Takoma Park. D.C.

19. Oct 13 1947 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1947 at 6 30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1945 to Oct 12 1947 and that I last saw h.. alive on Oct 12 1947

	DURATION
Immediate cause of death: Cardio Vascular Renal syndrome	
Bronchopneumonia, atypical	
Due to: Cholelithiasis	
Due to:	
Other conditions: Secondary anemia	
Senility	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D Courtney MD M. D. or other

Address: 5601-4 16 N Grad DC Date signed: Oct 15 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

164a

09320

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince George's

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4718 Rhode Island Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carl Eugene Taylor

3. (b) Social Security Number 217-10-9778

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife: Margaret Taylor

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): April 2, 1905

8. AGE: Years: 42 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Virginia (town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Henry W. Taylor

13. Birthplace: Virginia

MOTHER 14. Maiden name: Ellen Gaunson

15. Birthplace: Virginia

16. Informant: Mrs. Ellen Taylor

Address: 5239 Rhode Island Ave, Wash D C

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 18 1947 (month) (day) (year)

Cemetery or crematory: Shreider Cemetery

Location: Westminister Md

18. Funeral director: F Gaschs sons

Address: Hyattsville Md

19. Oct 17 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1947 at 6 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
asphyxia	
Due to: Hanging	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 10-16-47

Where did injury occur? Hyattsville P G Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where) Rear 4701 R.I. Ave

Means of injury Hanged self with rope to Injury [illegible]

Deputy Medical Examiner

23. SIGNATURE ..... M. D. or other

Address Hyattsville Md Date signed 10-16-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09321

13b

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 8 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1333 Que Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ELSIE TAYLOR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30, 1920

8. AGE: Years	Months	Days	If less than one day
27	2	22	hrs. min.

9. Birthplace: Wilson, North Carolina
(Town, county, and state)

10. Usual occupation: Laundress

11. Industry or business: —

FATHER — 12. Name: Bernard Taylor

FATHER — 13. Birthplace: Wilson, North Carolina

MOTHER — 14. Maiden name: Martha Stauton

MOTHER — 15. Birthplace: Durhan, North Carolina

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 23, 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington D.C.

18. Funeral director: R. P. Porter

Address: 922 Pa ST. N.W.

19. Oct 23, 1947 (Date rec'd by registrar) Rowland D. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22nd 1947 at 9:35 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13th 1947 to Oct 22 1947 and that I last saw her alive on Oct 22nd 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 10/22/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09322

164c

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9604 Baltimore Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME James Earl Thomas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife: Ethel B. Thomas
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): November 5, 1902

8. AGE: Years	Months	Days	If less than one day
44	10	19	hrs. min.

9. Birthplace: Washington DC (Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business: Naval Research Laboratory

FATHER
12. Name: James Thomas
13. Birthplace: Brandywine, Md

MOTHER
14. Maiden name: Sarah Ann Harvey
15. Birthplace: Maryland

16. Informant: Ethel B. Thomas
Address: 9604 Baltimore Ave Berwyn

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 27. 1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington D.C.

18. Funeral director: F. Gasch Sons
Address: Hyattsville Md.

19. Oct 27 1947 (Date rec'd by registrar) James Seavy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 24 1947, at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Shot gun wound in left Chest	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Suicide Date of 10-22-47
Where did injury occur? Berwyn (City or town) Md (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Shot self with shotgun (Injured at work?)
Respty Medical Examiner

23. SIGNATURE: ..... M. D. or other
Address: Forestville Md. Date signed 10-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

C9323

Reg. Diat. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Prince Georges

City or town Bowie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

Bowie Laurel Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Bowie

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bowie Laurel Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Francis Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 1, 1907

8. AGE: Years 40 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Bowie, Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Railroad

FATHER 12. Name Stephen Thomas

13. Birthplace Maryland

MOTHER 14. Maiden name Emma Fleet

15. Birthplace Maryland

16. Informant Henrietta Smith

Address Bowie, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 9 47 (month) (day) (year)

Cemetery or crematory Ascension Ch

Location Bowie Md

18. Funeral director M. Gladding Sons

Address Bowie Md

19. Oct 8 1947 Mrs J. W. Yingling Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1947 at 7.00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Intra Cranial Hemorrhage	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Upper Marlboro Md Date signed 10-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 09324

Reg. Dist. No. 24 3

1. PLACE OF DEATH:

County: Prince Geo. Co.

City or town: Rural - Mitchellville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Pr Geo

City or town: Rural - Mitchellville Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. Queen Anne
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eliza Jane Tilghman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	widowed

6.(b) Name of husband or wife: James Henry Tilghman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unk 1860

8. AGE: Years	Months	Days	If less than one day
87			hrs. min.

9. Birthplace: Calvert Co. Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Abraham Jones

13. Birthplace: Unk

MOTHER — 14. Maiden name: Mary Elizabeth Coates

15. Birthplace: Unk

16. Informant: Nancy Ott

Address: 135 Adams St. N.W. Wash D.C.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct 24 1947 (month) (day) (year)

Cemetery or crematory: Mount Nebo

Location: Mitchellville Md.

18. Funeral director: Laurence Froeaca

Address: Mitchellville Md.

19. Oct 22 1947 (Date rec'd by registrar) Louise H. Peach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 1947 at 2 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Oct 1947 to 21 Oct 1947 and that I last saw her alive on 20 Oct 1947

Immediate cause of death	DURATION
Pulmonary Edema	3 days
Due to: Cardiac Insufficiency	Unk
Due to: Arteriosclerotic CVR disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert B Lawson MD
M. D. or other

Address: Upper Marlboro, Md. Date signed: 22 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09325

55 w

CERTIFICATE OF DEATH

Reg. Diat. No. 230

1. PLACE OF DEATH:
County: Prince George's
City or town: Greenbelt, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6 K Hillside Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ROSE G. VOLCKHAUSEN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William C.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 27, 1872

8. AGE: Years	Months	Days	If less than one day
75			..... hrs. ..... min.

9. Birthplace: New Jersey (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Peter Gougelmann
13. Birthplace: Switzerland

MOTHER
14. Maiden name: Marie Keysner
15. Birthplace: Switzerland

16. Informant: Walter R. Volckhausen
Address: 6 K Hillside Rd. Greenbelt, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/27/47 (month) (day) (year)
Cemetery or crematory: Edmonston Co. Cemetery
Location: Bettsville, Md.
18. Funeral director: M. W. Chambers Co.
Address: Riverdale, Md.

19. Oct 26 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-24-47 19..... at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-1-47 19..... to 10-24 19 47 and that I last saw h... alive on 10-24-47 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	one year
Due to: Arteriosclerosis	
Due to:	
Other conditions: Pernicious anemia	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James E. Andrews M. D. or other
Address: Greenbelt Md Date signed 10-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(168)

09326

CERTIFICATE OF DEATH

Reg. Diat. No. 246

1. PLACE OF DEATH:
County: Prince Georges Co.
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 6903 New Hampshire Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6903 New Hampshire Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Leroy Waters

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Hilda P. Young
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8-8-1894

8. AGE:

Years	Months	Days	If less than one day
53	1	24	..... hrs. ..... min.

9. Birthplace: Pr. Geo. County, Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: William Henry Waters
13. Birthplace: Lakeland, Md

MOTHER
14. Maiden name: Edith Alice Turner
15. Birthplace: Md.

16. Informant: Mr. Lawrence Waters
Address: 6903 New Hampshire Ave Tak. Pk. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 4, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Pa Ave Extended, Pr. Geo. County

16. Funeral director: J. Arthur Walters
Address: 734 Carroll St. NW Washington D.C.

19. Oct 2 " 1947 (Date rec'd by registrar) Mrs. Jos. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2 1947 at 3:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Oct 2 1947
and that I last saw him alive on Oct 2 1947

Immediate cause of death	DURATION
Pneumonia, Lobar	1 day
Due to	
Due to	
Other conditions: Acute Bronchial Asthma	20 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John N. Andrews M.D.
M. D. or other
Address: Silver Spring Md. Date signed Oct 2 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


OCT 4 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 09327

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Pr. George
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Pr. Geo
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4803 Tuckerman
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cecil M. Whitehead

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Harriett Whitehead
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Feb. 6 - 188+

8. AGE Years	Months	Days	If less than one day hrs.	min.
63	8	24		

9. Birthplace Fairfax Va
(Town, county and state)
10. Usual occupation Buyer - retired
11. Industry or business Woodyard - Lathyard
FATHER 12. Name Joseph Whitehead
13. Birthplace Va
MOTHER 14. Maiden name Selena Williams
15. Birthplace Va
16. Informant Selena A Elliott
Address 4803 Tuckerman St Riverdale
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/3/47 (month) (day) (year)
Cemetery or crematory Ft. Lincoln Cemetery
Location Wash. D.C.
18. Funeral director A W Chandlee Co
Address Riverdale md
19. Nov 1 1947 (Date rec'd by registrar) James Seavey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1947 at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30 1947 to Oct. 30 1947
and that I last saw him alive on Oct. 30 1947

	DURATION
Immediate cause of death Congestive Heart Failure	9 3 2
Due to Hypertensive Heart Disease	
Due to Generalized Arteriosclerosis	
Other conditions Inguinal hernia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. S. Clayman MD
M. D. or other
Address Mt. Rainier, Md Date signed 10/30/47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 a

09328

Reg. Dist. No. 245

1. PLACE OF DEATH: County: Pr Geo Co

City or town: Riverdale md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (If non-resident give residence of mother)

State: Md County: Pr Geo Co

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4800 Rittenhouse st

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Viola B. Williams

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced:

6.(b) Name of husband or wife: Stanley Williams

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 29 1880

8. AGE: Years: 67 Months: 8 Days: 29 If less than one day: hrs. min.

9. Birthplace: Del. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER: 12. Name: George Drakeman

13. Birthplace: Del

MOTHER: 14. Maiden name: Lucinda Dickerson

15. Birthplace: Del.

16. Informant: Wm Griffin

Address: Bladensburg md

17. Burial (Burial, cremation, or removal: Which?) Date thereof: Oct 30 1947 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Bladensburg md

18. Funeral director: J Gesch & Sons

Address: Hyattsville Md

19. Oct. 30 1947 (Date filed by registrar) Mrs. Jas Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28, 1947, at 9.05 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 15 1947 to Oct 28 1947 and that I last saw h alive on Oct 28 1947

Immediate cause of death: Cardio vascular Renal Disease — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Hyattsville, Md. Date signed: 10-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WS AH5 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1314 09321

Reg. Diat. No. 230

1. PLACE OF DEATH:
County: Prince George
City or town: Berwyn, 8601 54th Ave.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, Institution, or street address where death occurred:
8601 54th Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5401 Berwyn Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward Bluaher willingham

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: Anna V. willingham
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 10, 1870

8. AGE: Years	Months	Days	If less than one day
77	6	9	..... hrs. ..... min.

9. Birthplace: Virgina (Town, county, and state)
10. Usual occupation: watch maker
11. Industry or business: Retired

FATHER
12. Name: James Alexandra Willingham
13. Birthplace: Virgina

MOTHER
14. Maiden name: Lucetta ?
15. Birthplace: Virgina

16. Informant: Lynwood E. Willingham
Address: 1317 D St; N.E. Washington D.C.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Oct 22, 1947 (month) (day) (year)
Cemetery or crematory: Idealton Cemetery
Location: Culpepper Va
18. Funeral director: F Gascia sons
Address: Hyattsville Md.

19. 10/20 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 19 19 47 at 9:P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardio Vascular Renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... injured at work?

23. SIGNATURE: Deputy medical Examiner
M. D. or other
Address: Hyattsville md Date signed 10-1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

09330

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

57d

CERTIFICATE OF DEATH

Reg. Dist. No. 237

1. PLACE OF DEATH:
County: Prince George
City or town: Westwood - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2y
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Westwood - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: WILSON, ESTHER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	W	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 12 - 1898

8. AGE: Years: 49 | Months: 8 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Aquasco Md. (Town, county, and state)

10. Usual occupation: Retired Postmaster Clerk.

11. Industry or business: Federal Government

FATHER
12. Name: James B. Wilson
13. Birthplace: Aquasco, Md.

MOTHER
14. Maiden name: Henrietta Thomas
15. Birthplace: Aquasco, Md.

16. Informant: Miss Ellen Wilson
Address: Brandywine, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Oct. 4-47. (month) (day) (year)
Cemetery or crematory: St. Paul's
Location: Bryan's, P.G. Co., Md.

18. Funeral director: Fletcher Brothers
Address: Upper Marlboro, Md.

19. Oct 3rd 1947 (Date rec'd by registrar) Mrs Henry B. Cartee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 2 19 47 at 3:25 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 1 19 47, to Oct 2 19 47
and that I last saw her alive on Oct 1, 1947 18

Immediate cause of death	DURATION
RESPIRATORY FAILURE	
Due to: INTRACRANIAL PRESSURE	
Due to: CEREBRAL OR CEREBELLAR TUMOR	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: /
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Alfred R. Lapen, M.D. M. D. or other
Address: AQUASCO MD Date signed: Oct 3 1947

VS A15 9-45.1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09331

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 hrs. 40 mins.

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution? 15 hrs. 40 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Mitchellville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Highway Store
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Baby Boy Wine

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	S

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 7, 1947.

8. AGE:

Years	Months	Days	If less than one day
—	—	—	15 hrs. 40 min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Leroy Franklin Wine
13. Birthplace: Va.

MOTHER
14. Maiden name: Theresa Veronica Valencia
15. Birthplace: Md.

16. Informant: Mrs. Leroy Wine
Address: Mitchellville, Md.

17. Cremation
(Burial, cremation, or removal. Which?)
Date thereof: 9 Oct 1947
(month) (day) (year)

Cemetery or crematory: Prince George's General Hospital

Location: Cheverly, Maryland

18. Funeral director: G. R. Bailey, Supt.

Address: Cheverly Md.

19. 10/10 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7 1947 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1947 to Oct 7 1947 and that I last saw h. alive on 7 Oct 1947

Immediate cause of death	DURATION
Atelectasis	8 hrs.
Due to: Prematurity	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert B Jasser M. D.

Address: Upper Marlboro Date signed: 7 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

09332

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos., 10 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1370 Kenyon St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY A. WRIGHT

3.(b) Social Security Number: 579-30-3021

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Leroy Wright
6.(c) If alive, give age: 19 years

7. Birth date of deceased (mo., day, yr.): February 2, 1927

8. AGE: Years	Months	Days	If less than one day
20	8	11	hrs. min.

9. Birthplace: Leesburg, Virginia (Town, county, and state)
10. Usual occupation: Maid - Hotel
11. Industry or business: -

FATHER
12. Name: Sam Thompson
13. Birthplace: Leesburg, Virginia

MOTHER
14. Maiden name: Ruth Garden
15. Birthplace: Leesburg, Virginia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 13, 1947 (month) (day) (year)
Cemetery or crematory
Location: to Washington, D. C.
C.V.
18. Funeral director: The Lewis Funeral Home
Address: 1508 Ninth St., N.W. Wash. D.C.

19. Oct 13, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 13th 1947 at 4 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2nd 1947 to Oct 13th 1947
and that I last saw her alive on Oct 12 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7½ mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Duncan M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 10/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15